Received 4/13/2017 3:56:23 PM Commonwealth Court of Pennsylvania

Filed 4/13/2017 3:56:00 PM Commonwealth Court of Pennsylvania
1 PEN 2009

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Penn Treaty Network America Insurance Company in Rehabilitation AND In Re: American Network Insurance Company in Rehabilitation	No. 1 PEN 2009 No. 1 ANI 2009

REPLY MEMORANDUM IN FURTHER SUPPORT OF APPLICATION OF THE HEALTH INSURERS FOR LIMITED INTERVENTION AND DETERMINATION OF AUTHORITY TO USE ESTATE ASSETS TO PAY "UNCOVERED BENEFITS" IN LIQUIDATION

INTRODUCTION

Aetna Life Insurance Company, Anthem, Inc., Cigna Corporation, HM Life Insurance Company, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, QCC Insurance Company, United Concordia Life and Health Insurance Company, United Concordia Insurance Company and UnitedHealthcare Insurance Company (collectively, the "Health Insurers"), through their undersigned counsel, hereby submit this reply brief in order to respond to the Brief in Opposition to the Application of the Health Insurers for Limited Intervention (the "Liquidator's Brief") filed by Teresa D. Miller, as Insurance Commissioner of Pennsylvania and in her capacity as Statutory Liquidator (the "Liquidator") of Penn Treaty Network America Insurance

Company ("PTNA") and American Network Insurance Company ("ANIC" and, together with PTNA, the "Companies").

ARGUMENT

A. The Court's Ruling on the Settlement Agreement Does Not Resolve the Question of the Health Insurers' Standing as to the Pending Application.

The Liquidator argues that the Court has definitively ruled that the Health Insurers do not have standing for any purpose in the proceedings, including the present challenge to the use of estate assets to pay "Uncovered Benefits."[1] The Liquidator cites the Court's Memorandum Opinion and Order, dated September 23, 2016 (the "Settlement Order"), for this proposition. The Health Insurers maintain that the Settlement Order does not bar the Health Insurers from objecting to the Liquidator's proposal to pay Uncovered Benefits.

The Liquidator argues that the Settlement Order is "law of the case" with respect to all issues involving the Health Insurers' standing. But the Settlement Order only indicates that the Health Insurers did not establish a sufficient interest in the matters covered by the Settlement Agreement that was the subject of the Settlement Order. And the Court made no findings of fact that have any application to the current situation. For example, the Court did not find that the Health Insurers would not pay assessments or suffer any loss as a result of

[1] "Uncovered Benefits" are benefits that would be within the terms and limits of a policy but accrued more than thirty days after the entry of the liquidation order and exceed the applicable guaranty association limits.

assessments (as the Liquidator argues here). Indeed, the Court made no determination of whether the Health Insurers have standing to challenge the use of estate assets to pay Uncovered Benefits.

Moreover, in the Settlement Order the Court did not overrule the objections of the Health Insurers on the basis of standing. Although the Health Insurers' standing was discussed as a threshold matter, the Court went on to evaluate the merits of their objection and determined that the settlement between the rehabilitator and the shareholder of Penn Treaty was within the rehabilitator's discretion given the risk inherent in the issues being resolved. *See Settlement Order* at 4, 8-9 ("The Health Insurers are too dismissive of the risk posed by the complex tax issues involved in this cases....The Court defers to the Rehabilitator's assessment of the risk inherent in these complex issues and her judgment that the Settlement Agreement is in the best interests of the policyholders, claimants and the public."). The ruling was not based on the proposition that no party has standing to challenge the settlement.

Regardless, the law of the case doctrine does not apply to the current circumstances. Rather, the law of the case doctrine "refers to a family of rules [] embody[ing] the concept that a court involved in the later phases of a litigated matter should not reopen questions decided by another judge of that same court or by a higher court in the earlier phases of the matter." *Famageltto v. Cty. of Erie*

Tax Claim Bureau, 133 A.3d 337, 347 (Pa. Commw. Ct. 2016) (internal quotation and citation omitted). The issue here was decided in the same court by the same judge. In Pennsylvania, "[a] court has the inherent power to reconsider its own rulings." *Wood v. E.I. du Pont de Nemours & Co.*, 829 A.2d 707, 710-11 (Pa. Super. Ct. 2003). Thus, even assuming the decision could be construed as a total bar on the Health Insurers' participation in this receivership, the Court is not barred from reconsidering its own decision.

Indeed, earlier in the case, the Court believed that the Health Insurers were sufficiently important to the receivership process to include them in the multi-party rehabilitation group that participated in the negotiation of two attempts at a rehabilitation plan. In that connection, the Court rejected the Policyholder Committee's contention that the Health Insurers lacked standing to make formal comments on the Second Amended Plan of Rehabilitation, which contemplated the liquidation of the majority of both Penn Treaty and ANIC. *See* Memorandum Opinion and Order dated April 17, 2015 (rejecting the Policyholder Committee's motion to strike the Formal Comments of the Health Insurers). The economic nexus of the Health Insurers to the rehabilitation plan is the same as the economic nexus to the distribution of assets in liquidation. In fact, in connection with the proposed Second Amendment Plan of Rehabilitation, at the Court's invitation, the Health Insurers fully briefed and argued the issues raised in the Application

regarding the use of estate assets to pay Uncovered Benefits in liquidation. Although that was in the context of a plan of rehabilitation, that plan contemplated the liquidation of the majority of the Companies and therefore raised the very same issues as those raised in the Health Insurers' present Application.

The Health Insurers have been active participants in virtually all aspects of these proceedings for over three years. As discussed below, there can be little question that the outcome of these proceedings will affect them significantly. Courts of appeal have held that where a party has been an active participant for a substantial portion of a case, it is not appropriate to deny that party standing on an ongoing basis. *City of Cleveland v. Ohio,* 508 F.3d 827, 844 (6th Cir. 2007); *see also, e.g.*, *SEC v. Wencke*, 783 F.2d 829, 834 (9th Cir. 1986) (finding that a non-party that did not intervene had standing to appeal because it participated in the lower court proceedings and had a "legitimate interest" in the outcome of the appeal) (citations and quotation marks omitted); *Curtis v. Des Moines*, 995 F.2d 125, 128 (8th Cir. 1993) (finding that although the appellees had not intervened, they had a right to participate in the appeal because they actively participated in the proceedings, made appearances to contest the issues, and were treated as parties by the district court's acts of accepting their briefs and rulings on their arguments). The same policy reasons underlying those decisions in the appellate context exist

with respect to the Health Insurers' involvement in the Companies' receivership proceedings.

B. The Health Insurers Meet the Test for Intervention and Standing Under Pennsylvania Law.

The Liquidator argues that the Health Insurers do not have a direct and substantial interest in distribution of the assets to pay Uncovered Benefits. Liquidator's Brief at 12. It does not appear that the Liquidator contests the proposition that every dollar that is paid towards Uncovered Benefits is a dollar that will have to be assessed against the Health Insurers and other member insurers. Indeed, this proposition is not disputable, and it is exactly the type of causal connection envisioned in the Pennsylvania cases on standing beginning with *Wm. Penn Parking Garage v. City of Pittsburgh*, 346 A.2d 269 (Pa. 1975). Instead, the Liquidator attempts to deflect attention from this fact by raising two sets of arguments. First, the Liquidator argues that standing should be governed by concepts of a statute's "zone of interest," and that the Health Insurers are not in the zone of interest. Second, the Liquidator argues that the Health Insurers will not suffer any loss due to premium tax offsets and other statutory mitigations, or alternatively, their loss is too speculative at this time to give them standing. Neither argument has any merit, and the unvarnished fact remains that the loss that will be suffered by the Health Insurers has exactly the causal connection to the

issues in the Application which give the Health Insurers standing under *Wm. Penn Parking* and its progeny.

1. The "Zone of Interest" test proposed by the Liquidator is not the Law in Pennsylvania

Rather than using the causation test prescribed by Pennsylvania case law, the Liquidator suggests a new test for standing based on the "zone of interests protected by Article V." Liquidator's Brief at 14. But this is not a requirement laid down by Pennsylvania courts in the cases on standing and a citation of authority by the Liquidator for this rule is noticeably absent. In *Johnson v. American Standard*, 8 A.3d 318 (Pa. 2010), the Pennsylvania Supreme Court acknowledged that Pennsylvania law is "arguably unclear as to when courts must examine the relevant zone of interests" test set forth by the Supreme Court of the United States in *Ass'n of Data Processing Serv. Org., Inc. v. Camp*, 397 U.S. 150 (1970). *Am. Standard*, 8 A.3d at 333. The Court then clarified this uncertainty in the law:

> [W]e reiterate what has been stated before: in Pennsylvania, a party must be aggrieved in order to possess standing to pursue litigation. Aggrievability is obtained by having a substantial, direct, and immediate interest in proceedings or litigation. When the standards for substantiality, directness, and immediacy are readily met, the inquiry into aggrievability, and therefore standing, ends. Should, however, a party's immediate interest not be apparent, a zone of interests analysis may (and should) be employed to assist a court in determining whether a party has been sufficiently aggrieved, and therefore has standing.

Id. The Court further clarified that the zone of interest component of standing is "merely a guideline that may be used to find immediacy, and not . . . an absolute test, as the Superior Court used below." *Id.* The zone of interest analysis provides guidance when the causal connection is not clear. It is not, as the Liquidator suggests, a dispositive factor. In this case, reliance on the zone of interest "guideline" is not needed; there is a direct causal connection between the action (payment of Uncovered Benefits) and the injury to the Health Insurers (increased guaranty association assessments).

Moreover, the Liquidator's formulation of the "zone of protected interests" does not get her where she wants to go. She refers to the preamble to Article V, which states that the insurance receivership laws were promulgated to protect the interests of "insureds, creditors and the public generally." Article V is not an exclusive statement as to who has standing in a case. If it were, any member of the public affected by the receivership would be in the "zone of protected interests." If the Liquidator is really worried about floodgates of standing (Liquidator's Brief at 13), adopting the prologue to Article V as the test would certainly throw the gates wide open.

Further, the Health Insurers are not seeking general, but only limited intervention to protect a narrow interest. As to that interest, they have standing under the applicable Pennsylvania case law. Contrary to the Liquidator's assertion,

the law of standing does not require that the Health Insurers have a legally enforceable "claim" against the estate. Liquidator's Brief at 13. This is exactly the contention that was rejected in *Wm. Penn Parking*. "The requirement that an interest be 'direct' simply means that the person claiming to be aggrieved must show causation of the harm to his interest by the matter of which he complains." *Wm. Penn Parking*, 346 A.2d at 282 (citation omitted). Showing a legal connection is not required:

> Some of our cases speak in terms of requiring the interest invaded by the challenged conduct to be a 'legal right' before standing may be conferred on the plaintiff. To some extent, the language is a remnant of an older approach....However, this test proved to be unsatisfactory, and has now been generally disregarded.

Id. at 285 (internal citations omitted). The degree of causal connection in this case is clear. Every dollar of assets that is allocated away from the guaranty associations will result in a dollar of additional assessment to the Health Insurers and other member companies.

The Liquidator analogizes the Health Insurers to shareholders of a creditor and says that the Health Insurers have an "interest" in the guaranty associations. But the Health Insurers do not have an "interest" in the guaranty associations. Unlike investors in a corporation, the Health Insurers cannot dispose of their interest or refuse to make further investment. The Health Insurers have a statutory obligation to pay their portion of whatever losses the association incurs.

As pointed out by the Virginia Life, Accident & Sickness Insurance Guaranty Association ("VGA") in its letter of February 22, 2017, attached to the Health Insurers' opening brief as Exhibit 1, the Health Insurers are the principal parties that will be assessed to cover the economic cost of VGA's obligations to the Companies' policyholders. The relationship between the Health Insurers and the guaranty associations is more akin to that of principal to agent than shareholder to company. The guaranty associations act as the agent of the member insurers in the receivership and as a conduit for gathering the assessments. The principal should have standing when the agent has standing. Direct privity is not required under Pennsylvania law. *See, Keener v. Zoning Hr'g Bd. of Millcreek*, 714 A.2d 1120, 1122-23 (Pa. Commw. Ct. 1998) (citing *Acorn Dev. Corp v. ZHP* 523 A.2d 436 (Pa. Commw. Ct. 1987) (establishing that a mortgage holder on a piece of property has standing in a zoning case even though it does not have title to the relevant property). Certainly the Health Insurers are at least as connected to this proceeding as a mortgage holder is to a zoning matter. The mortgage holder's interest is conditional: its financial interest is only affected if there is a default. The Health Insurers' interest is affected directly by the payment of Uncovered Benefits without regard to the occurrence of any conditions.

2. The Health Insurers' Will Suffer Losses Even After Application of Premium Tax Offsets or Other Statutory Mitigation

The Liquidator's argument that the Health Insurers have no standing because they will not have any loss from the assessments they pay to the guaranty associations is based on the false premise that the Health Insurers will pass the entire loss along to their policyholders or the public through surcharge and premium offset statutes. As discussed below, premium tax offsets and other statutory mitigation mechanisms are not available in all states. Further, even where they are available the Liquidator completely ignores a fundamental financial calculation inherent in the application of such mechanisms: the time value of money.

There are several states that have no recovery mechanism for assessments, such as Illinois, Alaska, Maryland, and New Mexico, and others that permit only partial recovery, most notably, New Jersey. In these states, the loss, or a significant portion of it, will reside with the member insurers. The Declaration of James P. McDermott, submitted herewith and attached as Exhibit 1 hereto (the "McDermott Affidavit"), identifies those states and totals the amounts that the Health Insurers will not recoup as a result of the law in those states. It is expected that the Health Insurers not recover amounts in those states totaling $85.9 million based on current estimates of guaranty association assessments.

In addition, under nearly all of the regimes, the Health Insurers will be required to recover their cash outlays over a period of many years. Under those statutory regimes, the time value of the cash outlays is not recovered. While most of the cost of the guaranty association is passed back to state taxpayers and, in some cases, policyholders, the guaranty association member insurers (including the Health Insurers) are providing interim financing for one to twenty years without any compensation. As set forth in the McDermott Affidavit, the cost to the Health Insurers of that financing is expected to be approximately $214.1 million.

The Liquidator inaccurately depicts public statements of the Health Insurers as standing for the proposition that the Health Insurers will have no losses from the assessments resulting from the liquidation of the Companies. In fact, what they say is that each of the Health Insurers has been forced to recognize a large estimated financial loss, which they expect to recover in *large part* over time. But the difference between the loss recognized and the potential recovery is still a number well in excess of ten million dollars, and more than enough to demonstrate a substantial interest in the distribution of the estate's assets.

The Liquidator argues that because the Health Insurers are large companies, their loss is not "substantial" and they should therefore be denied standing. Liquidator's Brief at 17-18 ("Thus, even if United Health were forced to pay the entire alleged $40 million assessment for the [Uncovered Benefits], the direct harm

claimed in the Application amounts to less than 0.05% of its revenue last year."). A measurement of the loss against a company's revenue is a preposterous test and not supported anywhere in the law. If companies the size of the Health Insurers disclose the assessments in public financial statements, they are doubtless not trivial, as the Liquidator suggests.

The Liquidator's argument attempts to shift the focus from where it belongs, which is her plan to use over $100 million to pay claims that cannot be allowed under Pennsylvania law. Indeed, the Liquidator does not even attempt to address this point. Once the Health Insurers have demonstrated that they have an economic interest in the outcome, the question is not whether they can afford to take the loss, but whether the loss has a substantial relationship to the Liquidator's proposed course of action.

3. The Harm to the Health Insurers is Not Speculative

The Liquidator argues that "The Health Insurers' Application is supported only by speculation, assumptions, and conclusory statement regarding potential harm." Liquidator's Brief at 15. In fact, the harm is sufficiently choate and immediate that the statutory accounting rules imposed by the Liquidator, as a regulator, and other regulators require the Health Insurers to quantify and recognize the assessments in their financial statements no later than the end of the quarter following the date on which the liquidation order is entered. Statement of

Statutory Accounting Principles No. 35 - Revised "SSAP 35R," with which the Health Insurers and all member insurers must comply, prescribes rules for when guaranty association assessment liability must be recognized. SSAP 35R states:

> Consistent with ASC 405-30-25-1, entities subject to assessments shall recognize liabilities for insurance-related assessments when all of the following conditions are met…:
>
> a. An assessment has been imposed or information available prior to issuance of the statutory statements indicate that it is probably that an assessment will be imposed.
>
> b. The event obligating an entity to pay an imposed or probably assessment has occurred on or before the date of the financial statement.
>
> c. The amount of the assessment can be reasonably estimated.

SSAP 35R at paragraph 4. Here, all three conditions are met. The entry of the liquidation order will necessitate that the guaranty associations make assessments to pay their statutory benefits. As set forth in the McDermott Affidavit, the Health Insurers have recorded liabilities aggregating hundreds of millions of dollars related to this liquidation.

The Liquidator argues that the Health Insurers' Application is premature because the Liquidator has not yet filed an application for the distribution of assets to fund Uncovered Benefits. Liquidator's Brief at 16. Yet at page four of the Liquidator's Brief, she states her intention to do so. Moreover, the Liquidator requested, and the Court approved, the restructuring of policy liabilities in

liquidation to split the policy liabilities between their "covered" and "uncovered" portions in order to, among other things, allocate estate assets on that basis. *See* Liquidator's Statement Regarding Restructuring of Insurance Liabilities in Liquidation, dated December 22, 2016, at 5-6 ("assets of the Companies will first be set aside to pay costs of estate administration and for contingencies. Then the remaining assets will be allocated to the GAs (Covered Benefits Assets) and to the portion of the Companies' Policy Liabilities that are not assumed, continued or guaranteed by the GAs (Uncovered Benefits Assets) based on the respective separate GPRs for the respective Covered Benefits and Uncovered Benefits."). Thus, the Liquidator's intended course is not a mere shot in the dark by the Health Insurers; the Liquidator discussed it in granular detail in a twenty page Restructuring Statement filed with the Court.

Moreover, the question of standing is ripe for determination. The Liquidator clearly and unequivocally opposes the Health Insurers' involvement in any dispute involving the funding of Uncovered Benefits. At a minimum, the issue of standing can and should be resolved now so that the Health Insurers and the guaranty associations know who will have standing in connection with the application the Liquidator intends to file. As set forth in the February 22, 2017 letter from the VGA, if the VGA determines that the Health Insurers lack standing, they may decide to intervene.

C. The Doctrine of Exhaustion of Administrative Remedies Does Not Act as a Bar to the Health Insurers' Right to Intervene in These Proceedings.

The Liquidator argues that "[s]tatutory law makes clear that the Health Insurers must rely on state Guaranty Associations to speak on their behalf . . ." but cites no statute to that effect, and there is none. The Liquidator recognizes that the guaranty associations have standing to challenge the payment of Uncovered Benefits, but leaps from there to the conclusion that their standing is exclusive. The Liquidator cites no authority for this proposition, and the law of Pennsylvania on standing is otherwise. Pennsylvania case law abounds with situations where multiple parties have standing to contest the same issues. *See, e.g.*, *Wm. Penn Parking*, 346 A.2d at 287 ("To deny standing to persons who are in fact injured simply because many others are also injured would mean that the most injurious and widespread Government actions could be questioned by nobody. We cannot accept that conclusion.") (citation omitted); *Sch. Dist. of the City of Erie v. Hamot Med. Ctr. of the City of Erie*, No. 138-A-1989,1989 WL 225736, at *4-5(Ct. Com. Pl., Erie Cty. Apr. 24, 1989) (School district and City both allowed to intervene in action challenging medical center tax exemption.)

There is nothing in Pennsylvania law that would eliminate the Health Insurers from having standing just because a guaranty association might also have standing. The case law is clear that questions of standing are evaluated on whether the party's interest is direct and substantial and bears a sufficiently close causal

connection to the disputed action. The Liquidator seeks to change that rule and make a party's standing dependent on its relationship with another party that might also have standing. Pennsylvania courts have time and again rejected this approach.

Moreover, the Liquidator's argument does not really make sense, nor would it be feasible. The remedy sought by the Health Insurers is the legal distribution of the estate's assets. The exercise of protest rights against the guaranty associations will not lead to a decision on those issues, but only on the issue of whether the guaranty associations will intervene in the receivership to protect the interests of the Health Insurers in a legal distribution of the assets. Even after the administrative determinations, the remedy is still far in the distance.

The Liquidator's approach is really designed to prevent any challenge to her actions. Under her approach, she would file an application for the distribution of assets. The Health Insurers would then have to make demand on all of the guaranty associations to intervene and oppose the application. As to those that refused, the Health Insurers would then need to take appropriate appeals. In the meantime, would the Liquidator hold her distribution application in abeyance? If the appeals were denied, would the Liquidator then agree that the Health Insurers had the requisite standing? The Liquidator's Brief is unclear on this point, but it seems unlikely that she would agree. If she would not agree, then would the

Health Insurers need to pursue litigation against the guaranty associations in the various state courts? If so, would the Liquidator continue to hold the distribution application in abeyance while the litigation was pending? The impracticality of the Liquidator's approach underscores the reasons that the Pennsylvania courts have not adopted a rule that requires a party that would satisfy the requirements of standing to compel another party that also has standing to pursue litigation on its behalf.

D. Denying the Health Insurers the Right to Intervene Would Violate Due Process.

Due process requires that the Health Insurers be permitted to intervene to protect their unique interests with respect to the use of estate assets for the payment of Uncovered Benefits. The guaranty associations and NOLHGA cannot adequately represent the Health Insurers' interests. Because they pass through 100% of the costs of their activities to member insurers through assessments, including the Health Insurers, the guaranty associations simply do not have the same interests the Health Insurers have in reducing the size of those assessments.

The Liquidator's efforts to avoid the requirements of due process are unavailing. The only new case cited by the Liquidator, *Petty v. Hosp. Serv. Ass'n of Ne. Pa.*, 611 Pa. 119, 135 (2011), does not even discuss the requirements of due process, much less provide support for excluding the Health Insurers. Contrary to the Liquidator's contentions, it is well established that imposition of increased

costs on a person to provide insurance coverage to others constitutes direct and substantial pecuniary harm making a person "aggrieved" and therefore entitled to due process. *Pa. Ass'n of Home Health Agencies v. Commw. of Pa. Ins. Dep't*, 119 Pa. Commw. 495, 502 (1988) (finding that association of health agencies was a "person aggrieved" by insurance commissioner's revision of workers' compensation rates, and vacating order denying Association's petition for review); *accord Pa. Coal Mining Ass'n v. Ins. Dep't*, 471 Pa. 437, 449 (1977) (coal companies required to bear costs of increased insurance rates for required black lung insurance coverage entitled to due process).

CONCLUSION

For the reasons set forth above, the Health Insurers respectfully request that the Court enter an order granting limited intervention to the Health Insurers for purposes of the Application and finding that the assets of PTNA and ANIC may not be used for the payment of Uncovered Benefits or payment to a cell of a captive insurance company to be used for the payment of Uncovered Benefits.

Respectfully submitted,

Dated: April 13, 2017

MORGAN, LEWIS & BOCKIUS LLP

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EXHIBIT 1

Declaration of James P. McDermott

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Penn Treaty Network America Insurance Company in Rehabilitation	No. 1 PEN 2009
AND	
In Re: American Network Insurance Company in Rehabilitation	No. 1 ANI 2009

DECLARATION OF JAMES P. McDERMOTT IN SUPPORT OF THE APPLICATION OF THE HEALTH INSURERS FOR LIMITED INTERVENTION IN ORDER TO SEEK DETERMINATION OF AUTHORITY TO USE ESTATE ASSETS TO PAY "UNCOVERED BENEFITS" IN LIQUIDATION

I, James P. McDermott, hereby state:

1. I am a Managing Director and Practice Leader of Alvarez & Marsal Insurance and Risk Advisory Services, LLC ("Alvarez & Marsal"). My job responsibilities include the supervision of the firm's insurance practice as well as financial and management consulting. I have spent over thirty years in the insurance and risk advisory space including roles as Chief Financial Officer and Chief Executive Officer of insurance and insurance holding companies. I hold Bachelor's in Business Administration degrees in accounting, actuarial science and quantitative analysis and have held (currently inactive) a license as a Certified Public Accountant.
2. Since 2012, my colleagues and I at Alvarez & Marsal have provided information and analysis to Aetna Life Insurance Company, Anthem, Inc.,

Cigna Corporation, HM Life Insurance Company, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, QCC Insurance Company, United Concordia Life and Health Insurance Company, United Concordia Insurance Company and UnitedHealthcare Insurance Company (together with their affiliates, the "Health Insurers") in connection with the receivership proceedings of Penn Treaty Network America Insurance Company and American Network Insurance Company (together, the "Penn Treaty Companies"). I submit this Affidavit on behalf of the Health Insurers in support of their Application for Limited Intervention in Order to Seek Determination of Authority to Use Estate Assets to Pay "Uncovered Benefits" in Liquidation (the "Application for Limited Intervention").

3. This Affidavit is based on a review of the publicly available information described herein and upon analyses and computations performed by me or my associates under my direct supervision.

4. Based on my review of the Statement of Statutory Accounting Principles No. 35 - Revised, the Health Insurers are required to recognize loss associated with guaranty association assessments in their financial statements filed as of the end of the quarter following liquidation. Based on our review of publicly available financial statements, the Health Insurers have recorded or estimated aggregate losses associated with guaranty association assessments for the Penn Treaty

Companies in excess of $939 million. We anticipate that the ultimate gross recognized losses (prior to offset or recovery) required to be recorded by the Health Insurers in respect of their guaranty association assessments for the Penn Treaty Companies will be in excess of $1.1 billion.

5. Based on our analysis and understanding of the methodologies used by guaranty associations to allocate assessments, as described in certain statutes and operating plans governing the associations, and data reported in insurance company annual statements, we estimate that collectively the Health Insurers' liability for assessments represents approximately 42% of the total of all assessments to all guaranty association member companies arising out of the liquidation of the Penn Treaty Companies.

6. In her Answer to the Application for Limited Intervention, the Liquidator states that the Health Insurers will recover the entirety of their loss through the premium tax offset and policy surcharge provisions in the guaranty association statutes in each state. However, current statutes would not allow for a full recovery. The following summarizes the provisions for recovery based upon current statutes:

    a. In five states, there is no mechanism by which insurers can recover assessments;

b. In three states, insurers can recover only fifty percent of assessments via premium tax offsets over a period of five years;

c. In forty states, insurers can recover the full amount of assessments by utilizing premium tax offsets over periods ranging from one to twenty years following the year of the assessment;

d. In two states, insurers are either permitted or required to recover assessments by adding a premium surcharge to their currently filed rate as a means to recover the assessments. It should be noted that in the state where the surcharge is optional, the addition of premium surcharges could be infeasible because it might raise the cost of a policy beyond a level that would be competitive with the products of other companies (such as health care services corporations or health maintenance organizations) that are not members of guaranty associations and therefore do not pay assessments.

7. Attached as Exhibit 1 is a list of the states where assessments will be made. Exhibit 1 sets forth the amount of the assessments that can or cannot be recovered by the Health Insurers through premium tax offset or surcharge. The

amount that is not allowed to be recovered by the Health Insurers totals $85.9 million.

8. As stated above, the recovery of assessment payments (where available) is made over a period of one to twenty years after a payment is made. The recovery of payments through premium tax offsets or premium surcharges does not include any compensation for the time value of money associated with the fronting of the payments made by the member insurers.

9. We have estimated the time value of money associated with the premium offsets and policy surcharges assuming all assessments are paid in 2017 and that each of the Health Insurers undertakes to recover payments made by it either in the statutorily prescribed time period or, in states with surcharges, over a five-year period. We have assumed that the Health Insurers will undertake to surcharge policies regardless of market conditions. In performing these computations, we have assumed a 6.07% cost of capital for the Health Insurers which is equal to the weighted average cost of capital for the insurance sector in general, as calculated by New York University ("NYU") Stern School of Business Professor of Finance Aswath Damodaran, and published on the NYU Stern School of Business website. We have not attempted to determine the cost of capital for the Health Insurers, but believe that the actual cost of capital for the Health Insurers could be higher. Note that the use of a higher number

would result in a greater loss in time value of money as a result of the delay in recovering assessment outlays. Our analysis of the time value of money costs is set forth on Exhibit 1. It demonstrates that the loss to the Health Insurers related to the time value of money paid to the guaranty associations and recovered over a period of one to twenty years is $214.1 million.

10. Exhibit 1 demonstrates the total economic cost to the Health Insurers (i.e., the amount that is not allowed to be recovered plus the time value of money cost) is $300.0 million.

This declaration is made on April 13th, 2017, subject to the penalties of 18 Pa. C.S. § 4904 relating to unsworn falsification to authorities.

EXHIBIT 1

EXHIBIT 1

Total Economic Costs Related to the Penn Treaty Companies ($ millions)[1]

	Gross Assessments		Recovery Mechanism Details		Non-Recoverable Cost		Time Value of Money Cost		Total Economic Cost	
State	Net Covered Liability[2]	Health Insurers Est. Share	Recovery Method[3]	Nominal % Recovery	Total	Health Insurers Est. Share	Total	Health Insurers Est. Share	Total	Health Insurers Est. Share
AK	$ 1.1	$ 0.5	N/A	0%	$ 1.1	$ 0.5	$ -	$ -	$ 1.1	$ 0.5
IL	84.4	17.1	N/A	0%	84.4	17.1	-	-	84.4	17.1
MD	31.5	12.5	N/A	0%	31.5	12.5	-	-	31.5	12.5
MA	2.0	0.5	PTO	50%	1.0	0.3	0.2	0.0	1.1	0.3
NJ	144.6	105.7	PTO	50%	72.3	52.8	18.3	13.3	90.6	66.2
NM	8.2	1.6	N/A	0%	8.2	1.6	-	-	8.2	1.6
RI	1.7	0.8	PTO	50%	0.9	0.4	0.1	0.1	1.0	0.5
WV	3.4	0.7	N/A	0%	3.4	0.7	-	-	3.4	0.7
All Other[4]	2,412.3	986.9	PTO/Surcharge	100%	-	-	498.0	200.6	498.0	200.6
Grand Total	$ 2,689.1	$ 1,126.3	N/A	N/A	$ 202.7	$ 85.9	$ 516.6	$ 214.1	$ 719.3	$ 300.0

[1] *Amounts shown are rounded*

[2] *Based on LTCG projections as contained in their 4/10/17 memorandum to Charles Gullickson, which is published on NOLHGA's website in the following location: https://www.nolhga.com/resource/file/costs/NOLHGAMemorandum20170410.pdf*

[3] *N/A = No recovery mechanism; PTO = Premium Tax Offset*

[4] *Includes AL, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IN, IA, KS, KY, LA, ME, MI, MN, MS, MO, MT, NE, NV, NH, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WI, and WY*

CERTIFICATE OF SERVICE

I certify that on April 13, 2017, I caused a true and correct copy of the foregoing document to be served on the following persons by email at the email addresses indicated below:

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